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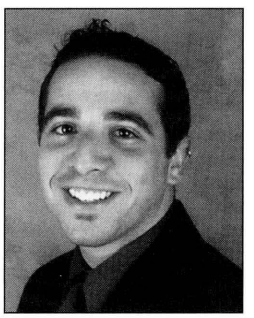
SOCIALIZED MEDICINE IN AUSTRIA: AN EVOLUTION OF PRACTICE AND POLICY

Mered S. Parnes



Origins of Medicosocial Ideology

The Austrian health care system is among the most impressive and functional of its kind, admired for its provision of accessible, high-quality coverage. (Crain Communications, p. 126) The Austrian scheme is noteworthy in that it allows individuals to be eligible for a full spectrum of medical care, inpatient or outpatient as needed, that is paid for in the form of an annual contribution based on income. (Main Association..., p. 6) Examination of medical models of this nature is particularly relevant at this time, as the industrialized world becomes increasingly conscious of rising health care costs and a disproportionately-growing global elderly population. The Austrian plan is itself not exempt from these problems, and must also make provisions and changes in order to continue to provide high-quality medical coverage to every citizen of the country. In recent years the Austrian federal government has begun to adjust the system, with the hopes that universal health care coverage will continue to be provided in the future.

In the twentieth century, the most significant occurrence in Austrian socialized care has been the establishment of a cohesively unified social security system, providing health insurance, accident insurance and pension insurance. The modern system has its origins in the late 1800s, when some types of workers began to pay into separate makeshift funds, individualized for different professions and locations. (Solsten and McClave, p. 109) As a result, the system is now structured on the basis of geographic region and occupation. (Main Association..., p. 3) Provision of health care in Austria is viewed as a responsibility of the public, firmly founded on the "solidarity principle": the idea that everyone earning wages must without exception be covered by social security. (Rasky, p. 1) The present-day system is legally based on the General Social Insurance Act of 1955, which outlines social security policy and discusses benefits and level of payments to be

collected. (Solsten and McClave, p. 109)

The first Austrian Ministry of Health was introduced in 1972 with the establishment of the Federal Ministry of Health and Environmental Protection, accompanied by the first "health and environment" plan and a reform of hospital law. Nearly thirty years later, the original Ministry has gone through a number of changes and now stands, since 1997, as the Federal Ministry of Labor, Health and Social Affairs. The duties of this Ministry include formulation of general health policy, provision of protection against possible risks to public health, formulation of preventive medical measures, monitoring and preventing the spread of infectious disease, and training of medical personnel in the public health sector. (Federal Ministry, p. 13) Several other federal departments also shoulder a small number of health-care-related responsibilities, including the Federal Chancellery's responsibility for such areas as consumer protection and food control and the Ministry of Science and Transport's responsibility for the university training of physicians. (Federal Ministry, p. 11)

Structure of the System

Social security coverage (health, accident, and pension insurance) is provided directly by private insurance institutions, all of which belong to the Main Association of Austrian Social Security Institutions (Hauptverband der Osterreichischen Sozialversicherungstrager). (Main Association..., p. 3) Interestingly, because physicians in Austria are employed through contract with the insurance institutions, the Austrian health care system is not "socialized" medicine in the sense that the term often implies — that is, that health care is provided directly by the state. (Solsten and McClave, p. 112) Twenty-eight insurance institutions exist, including nineteen that provide health care coverage exclusively and nine others that provide coverage in any one or a combination of the three areas of social security. Of the nineteen agencies specific to health insurance, nine are district institutions, one for each of the nine provinces (or *Laender*) of Austria, and ten are occupational institutions, providing care for specific types of professions (such as mining or farming). (Main Association..., p. 3)

Social health insurance services are available for all citizens who are employed (including the self-employed), unemployed, or pensioners, as well as for spouses and children under 18 not covered under their own policy. (European Communities and WHO, p. 30) Children can be covered as dependents up to age twenty-seven if they are students, and are covered indefinitely if illness or accident prevents them from working. In some situations parents and other relatives or life partners living in the same household may qualify as well. (Main Association..., p. 22) All told, some ninety-nine percent of the Austrian population qualify for health insurance. (European Communities and WHO, p. 30) The few who reside in Austria and do not qualify may register themselves for health insurance for a monthly contribution of between 856.60 and 3,345.60 schillings, depending on the individual's economic circumstances. (Main Association..., p. 7) (This is about $60 to $230 U.S. as of April 2000. (Oanda, p. 1)) The agency by which an individual is insured is determined by the province in which he lives and by his occupational situation. (European Communities and WHO, p. 30)

Although almost every Austrian citizen is provided with insurance under this system of social welfare, supplementary private insurance coverage is also available for purchase. In the early 1990s, thirty-eight percent of the population chose to make use of the option to purchase additional coverage. (European Communities and WHO, p. 30) The supplementary insurance can guarantee special amenities during inpatient hospital treatment or extra post-hospitalization outpatient treatment. (Feuerstein)

While the federal government is responsible for health legislation, formation of policy, and regulation of the insurance institutions that provide the care, it is provincial and municipal authorities and advisory boards, supervised by health officers, that serve to implement law and policy on the local level. (European Communities and WHO, p. 30) Within each provincial government, a Provincial Health Director — a physician with civil servant status — heads each provincial health department, advised by a Provincial Health Council. (Federal

Ministry, p. 14) Federal responsibility for this system rests largely, though not entirely, in the hands of the Federal Ministry of Labor, Health and Social Affairs. (Federal Ministry, p. 11)

Financing

Social security is chiefly financed by those whom it insures and, in the case of employees, by their employers as well. Should the revenues raised not cover social security costs, the difference is subsidized by the federal government from general tax revenues. The contribution for every individual is based on his profession and amount of income earned, and consists of a percentage of income to be paid for each of the three types of insurance (health, accident, and pension), depending on his employment situation. The rates are adjusted annually, with an annual cap that establishes a maximum contribution. (Main Association..., p. 6)

For those not self-employed, the employer is responsible for payment of half of the health insurance contribution (except civil servants, for whom the employer pays more than half). Contribution rates range from 6.40 percent (self-employed farmers) to 9.10 percent (which includes a number of employee and self-employed categories). Contribution caps for 1998 were either 42,000 or 49,000 schillings, depending on the law under which a person was insured. (Main Association..., p. 6) (This is about $2,720 or $3,170 U.S.) (Oanda, p. 1)

Provision of Care

For the most part, primary care in Austria is provided by general practitioners (GPs) and specialists with private practices, as well as by hospital outpatient departments and by outpatient medical facilities run by the insurance institutions themselves. (European Communities and WHO, p. 31) General practitioners are normally the first to be contacted in the case of illness. If the GP believes further examination or treatment is needed, he will refer the patient to a specialist or hospital. (Federal Ministry, p. 40) According to the most current available data, at the end of 1994, 30,500 physicians were practicing medicine, including 3,300 dentists and 6,650 physicians finishing their training or specialization. On average, 2.3 physicians (not including dentists or doctors in training) were available per 1,000 Austrians, a figure somewhat lower than that of the EU average, which sat at 2.7 per 1,000. (European Communities and WHO, pp. 30–31) In the United States, on the other hand, in 1995 2.1 physicians per 1,000 with an M.D. degree were active in patient care. (National Center for Health Statistics, p. 266)

Most doctors in private practice have a contract with one or more of the twenty-eight insurance institutions. Insured individuals who are in need of care are free to choose any physician (general practitioner or specialist) who is under contract with their insurance provider. (Federal Ministry, p. 40) If an insured patient chooses to see a physician who is not employed by his insurance carrier, the carrier will reimburse up to 80 percent of the amount that would have been paid to the doctor under contract. (Federal Ministry, p. 79) Payment is based on a system of insurance vouchers for three-month periods, so as a result patients are normally under the supervision of the same doctor for a minimum of three months. (European Communities and WHO, p. 31)

The insurance vouchers used by doctors to bill the health insurance institutions are called "patient certificates." Until 1997, the use of these forms was free of charge to patients. However, under most plans citizens now pay fifty schillings per voucher, a small fee to help to combat the rising cost of health care (about $3.50 U.S.). (Federal Ministry, p. 40; Oanda, p. 1) The issue of co-payment for health care is a very current topic in Austria, and discussions regarding further deductibles are continuing, though historically such proposals have generally been rejected. (Federal Ministry, p. 40)

Hospital Treatment

Hospital outpatient departments (OPDs) play a valuable role in providing medical care. At the end of 1996, there were 724 hospital outpatient departments in the country. Normally these departments treat patients when they are referred to the hospital by physicians in private practice. However, OPDs also treat patients in need of emergency care, as well as provide fol-

low-up care for former inpatients. (Rack, p. 75) Outpatient departments offer technical services that cannot easily be provided by doctors in private practice, primarily because it is possible for hospitals to purchase a wider array of expensive medical equipment. But OPDs are becoming more popular as a substitute for care provided by physicians in private practice, most notably in urban areas. (Federal Ministry, p. 41) This is not unlike the way emergency room care is now often used in the United States.

Austrian federal law mandates that the *Laender* are responsible for the establishment and maintenance of hospitals. They may do so by operating public hospitals or by arranging to use those that are privately owned. Over two-thirds of hospitals in Austria provide exclusively (or mostly) acute care, while the others offer non-acute care including rehabilitation and long-term care for chronic illness. (Rack, p. 73) Inpatient hospital treatment may be claimed when an illness requires medical treatment that would not be possible on an outpatient basis. The care is normally provided by the closest hospital in which the insurance agency of the insured has a contract with the hospital administration, or by a private hospital with which the agency has a contract. (Main Association..., p. 26)

Social health insurance allows patients "Standard Class" hospital care. For those persons covered by additional private health insurance, "Special Class" accommodations are available. The private insurance permits a patient to choose his physician, stay in a single or double room, and possibly to have better furnishings or meals, depending on what the facility provides. However, the medical services that are provided must be identical. (Rack, p. 73)

As of 1998, 315 hospitals were in service in Austria, providing 68,000 beds for inpatient use. (Rack, p. 73) Availability of beds for inpatient hospital care varies among the nine *Laender*, the fewest being available in Burgenland (6.5 per 1,000 inhabitants) and the most in Styria (10.9 per 1,000), with the national average at 9.2 per 1,000. By way of comparison, in the United States in 1997 3.2 community hospital beds were available per 1,000. (National Center for Health Statistics, p. 279) Excluding chronic illness, psychiatric commitment and long-term rehabilitation, 20 percent of Austrians on average are hospitalized once a year, the same figure as the EU average. (Rack, p. 74)

The social health care system supplies hospital care as long as doctors feel it is required, without time limits established by the insurance institutions or federal government. (Main Association..., p. 26) It would appear, then, that Austrian medical efficiency is responsible for the decrease in the average length of hospital stay: length of stay has dropped from 14.2 days in 1980 to 9.5 days in 1996, well under the EU average of 12.5 days. (Rack, p. 74) In the United States, the average hospital stay is shorter (5.7 days in 1996). (National Center for Health Statistics, p. 246) However, length of stay for American patients is often affected by what insurance companies will allow.

The freeing up of beds brought about by the shortening of hospital stays in Austria has actually resulted in a reduction of the number of beds in acute care hospitals. In all, 3,000 beds were removed between 1988 and 1998. At the same time, the number of hospital staff employed has risen sharply since 1980 (over fifty percent for medical and technical personnel as well as nursing staff), resulting in a greater number of available staff per acute care patient. (Rack, p. 74)

Monetary support for hospitals is made available through a dual financing system. The hospital authority is responsible for the creation and maintenance of hospitals, while the Standard Class operating costs are covered primarily by the health insurance institutions. The operating costs of Special Class arrangements are covered by private insurance and/or patient fees. (Rack, p. 80)

Recent Reform

Prior to World War I, as part of the Austro-Hungarian Empire, Austria, Hungary and the former Czechoslovakia shared not only comparable social and political systems, but similar health care arrangements as well. Even after the dissolution of the empire, health care in all three countries remained comparable until communism instigated reform for the Czechs and Hungarians. (Bennett et al., p. 2789)

Nationalized health care has remained in Austria, and has continued to function, under-

going a number of changes in policy. The most notable of these include the "mother-child passport," a provision instituted in 1974 (Federal Ministry, p. 49) to combat high rates of infant mortality by compulsory examination of expectant mothers and developing children and newborns. The program has had remarkable success in mortality reduction, bringing the mortality figure down from 14.3/1,000 live births in 1974 to 5.1/1,000 in 1998. (Rack, p. 87) In contrast, infant mortality in the United States was 7.2/1,000 in 1997. (National Center for Health Statistics, p. 132)

In March 1996, rising health care costs led the federal and provincial governments to agree upon what was to be the start of a large-scale progressive agenda for health care reform. The objective of the plan was to reduce the rate of cost increase within the system by reorganizing and streamlining the various departments related to health care. This was to be accomplished by clearly defining the responsibilities of each department to eliminate inefficient overlap. On the first of January, the 1997 Health Care Reform was introduced, applying the new changes to the health system. (Federal Ministry, p. 12)

The reorganization included major changes regarding the financing and management of hospital treatment. From 1978 until 1997, inpatient medical care had been paid for on a daily flat fee basis, regardless of the actual treatment provided. (Federal Ministry, p. 86) Hospitals were financed in this unlikely manner due to the way in which the underlying legal basis for hospital finance had been designed in 1978, with the establishment of the Hospitals Cooperation Fund (KRAZAF). (Rack, p. 80) The fund acted as a central planning organization for hospitals and, in addition to financing, had such other responsibilities as the authorization of hospital construction projects and decisions regarding the purchase of expensive medical equipment. (European Communities and WHO, p. 80)

KRAZAF financing was a complicated system in which health insurance institutions covered a calculated daily flat fee rate per patient, and the difference between that and what was required to cover hospital costs was paid cooperatively by the hospital authority, community associations and the provincial government. This arrangement provided no incentive for the hospital authorities to run their facilities in a cost-effective manner, as there was funding from these other bodies available to help cover costs. The beginning of 1997 saw the elimination of KRAZAF and in its place the creation of the Performance-Oriented Hospital Financing System (LKF). The new system provides each of the *Laender* with an individual budget and the financial autonomy to manage its own hospitals (European Communities and WHO, p. 80) and also allows for fee-for-service billing. (Rack, p. 81) The *Laender* budgets are funded by the social insurance institutions and the federal, provincial and municipal governments; furthermore, the LKF system is subject to ongoing review and development. (Federal Ministry, p. 86)

Lifestyle and Risk Behavior

There appear to be two somewhat contradictory views of Austria's health care standing. According to a recent study of health care systems, Austria sits among the top providers on the globe, ranking third among thirty nations examined by a British international research firm, MarketLine International, in 1996. Only Switzerland and Sweden were ranked higher, with Japan at number four; the United States came in at number twelve. Countries were ranked in terms of health expenditure per capita, life expectancy, infant mortality, main causes of death, number of doctors per capita and level of accessibility of medical care. (Crain Communications, p. 126)

For all of the medical services and technology available, however, the state of health of the nation is, for the most part, surprisingly ordinary. As well-designed as Austria's scheme for health care provision may seem, the country rates as only average among industrialized European nations with regard to a number of other health indices. In 1998, the World Health Organization (WHO) compiled an extensive collection of the most current available data (1993) regarding the state of health of the Austrian population. The WHO report ranks Austria in comparison to the 14 other EU nations along with Iceland, Norway and Switzerland; the findings are less impressive than one might expect from a country supposedly among the top

health care providers worldwide. In 1993, infant mortality sat at 6.5 deaths per 1,000 live births, just marginally lower than the EU average, 6.8/1,000. The age-adjusted annual mortality rate from cardiovascular diseases (CVDs) for those under the age of 65 is the fourth-highest among the 18 nations in the study, at 70.2 per 100,000. The age-adjusted annual cancer mortality rate for persons under age 65 was about average, at 86.2 per 100,000. (EC and WHO, p. 9) Noteworthy is the fact that mortality below the age of 65 is considered premature. (European Communities and WHO, p. 11)

However, Austria's health statistics have been far from static over the last few decades. The state of health of the population of Austria has been steadily improving since 1980 in comparison with the other nations studied. Significant progress has been particularly apparent for Austria in life expectancy increase (life expectancy at birth and at 65 years showed the greatest gains among all 18 countries), infant mortality, and accidental and violent death rate decrease (of which traffic accidents are the number one cause in Austria). Austria had in 1980 been ranked relatively poorly in terms of life expectancy, mortality as a result of accidental and violent death (second-highest) and death rates due to cancer and cardiovascular diseases. (European Communities and WHO, pp. 3, 9)

Life expectancy at birth in Austria as of 1998 stands at 73.3 years for men and 80 for women. (Rack, p. 69) Austria's life expectancy is very comparable to that of the U.S., which in 1997 was the highest it had ever been, at 73.6 years for men and 79.4 years for women. (National Center for Health Statistics, p. 139)

Cancer and CVDs remain the chief causes of death among the Austrian populace, amounting to 77.4 percent of all deaths. (Federal Ministry, p. 25) About 50 percent of deaths are due to cardiovascular disease, and mortality rates from CVDs are the second-highest in women and third-highest in men among the countries compared in the WHO report. (Rack, p. 70) However, though CVDs cause more deaths overall, under the age of 65 the primary cause of death is cancer. In addition, Austria has the fourth highest incidence of death from congenital anomalies between the ages of one and fourteen in the European Union, for both males and females.

From the ages of 15 to 34, the risk of death from external causes (accident, suicide or homicide) is fourth-highest for women and fifth-highest for men. From age 35 to 64, the death rate from diseases of the digestive tract is highest in the EU for men and third-highest for women. Male mortality from external causes is still among the highest for this age group. (European Communities and WHO, p. 12)

Perhaps the differing views of Austrian health care can be reconciled with sociological theory. In an article originally published in 1977, John and Sonja McKinlay conducted a review of compiled data relating to specific medical interventions thought to be the most important factors accounting for mortality decline in the Twentieth Century. These interventions were new treatments, introduced to prevent or effectively treat diseases like measles, polio, influenza, and pneumonia, among others. The results were surprising: the medical interventions were seen to have less influence on mortality from each disease than one would intuitively expect. In fact, the data show that most of the mortality decline witnessed during the course of the century for each of the diseases studied began to occur before a specific treatment for that disease was even introduced. (McKinlay and McKinlay, pp. 10–21) This indicates that social factors, e.g. improvements in sanitation, nutrition, and social habits (diet, work habits, exercise), may have had more of an impact on general health. This evidence suggests that in a given society, a point may be reached where medical intervention becomes secondary to sociological factors, and that progress in the promotion of health is limited by the willingness and the ability of the population to adjust their way of life. I propose that this may well be the case in Austria.

Traditionally, the Austrian diet is fatty and high in sugar and complex carbohydrates. Alcohol, particularly beer and wine, is typically consumed on a regular basis. Diet and drinking habits play a major role in determining the rates of incidence of cardiovascular disease and cirrhosis of the liver, for both of which Austria ranks among the highest in western Europe. (Solsten and McClave, p. 111)

Cardiovascular disease has in fact been linked to a number of risk factors related to

lifestyle, the prevalence of which can be valuable as indicators. The prevalence of hypertension, for example, for people over fifteen years of age is reported to be 7.3 percent for men and 7.9 percent for women. Obesity, another factor thought to put individuals at risk for CVDs, is pervasive in Austria, with 18 percent of males and 12 percent of females identified as overweight (body mass index [BMI] from 27–29.9). An additional 9 percent of males and 9 percent of females have been diagnosed with obesity (BMI of 30 or above). (European Communities and WHO, p. 24) The body mass index is a person's weight in kilograms divided by his height in meters squared (kg/m^2).

It is interesting to note that recent research in Austria has found that health risk behavior is more likely to be observed among the unemployed, particularly in men. Unemployed individuals are observed to drink more alcohol and in higher quantities, and are considerably more likely to smoke cigarettes. Unemployed men brush their teeth less often; jobless adolescents do not exercise as much and are more likely to have sleeping disorders. In men, systolic blood pressure is likely to be significantly higher among the unemployed than that of the employed. The incidence of chronic liver, respiratory and gastrointestinal diseases is also higher. In addition, the unemployed are more likely to require medical services. (Rasky et al., p. 760)

Because health awareness and behavior are significantly related to most of the primary causes of death in Austria, programs to promote consciousness of these causes have the potential to reduce factors leading to premature death. (European Communities and WHO, p. 12) In the mid-'80s, a movement began to initiate preventive programs to promote awareness and stem the tide of risk behavior, including alcohol consumption, smoking, and behaviors leading to high cholesterol. (Solsten and McClave, p. 111) Due to the growing emphasis on the idea that personal lifestyle choices can have considerable effect on one's health, the insurance institutions began to include the promotion of health awareness among the duties of the social health care system. It has become their intent to spread information they have gathered with regard to minimizing potential health-risk behaviors in everyday life. (Main Association..., p. 23) As of 1990, however, only slight changes had been observed in traditional behavior patterns. (Solsten and McClave, p. 111) In 1993 the Main Association of Austrian Social Security Institutions assembled a Prevention Advice Council for the purpose of continuing work in this area. (Main Association..., p. 23)

The Aging Issue

In recent years, due mainly to remarkable increases in life expectancy, the world's population has, on average, become older. The trend is expected to continue, chiefly caused by the declining incidence of premature mortality over the last hundred years. Advances in medical technology, including the use of antibiotics and vaccinations, as well as progress in the areas of nutrition, sanitation, and housing have ensured longer lives for millions of people worldwide. Advances in contraception have served to prevent a global population explosion of all ages, as world fertility rates have declined at the same time. The steep increase in the elderly population coupled with a global decrease in births has resulted in the current phenomenon, which has been called "population aging." (Demko, p. 1)

Increasing longevity in itself raises another issue: the consideration of when the prolonging of life is in itself a benefit, a subject that has recently come under close scrutiny in Europe as well as in the United States. Ethicists and those in the health care field alike have begun to examine whether recent scientific and technological advancements that provide a capacity to extend lifespan allow the elderly to live enjoyable and fulfilling lives, rather than merely delaying their deaths.

In Austria, population growth is compounded by an influx of foreigners, who have made a significant contribution to the population increase. The fall of the Soviet Union and the breakup of the former Yugoslavia generated a tremendous group of migrating asylum-seekers beginning in the mid-1980s, and continued until Austrian law in 1992 and 1993 began to limit the surge. (Solsten and McClave, p. 209) In the early 1990s, the Austrian Central Statistics Office (OSTAT) estimated that there were nearly a half million foreigners residing in Austria,

over 60 percent of whom were of Turkish or Yugoslav origin. (Schmid and Giorgi, p. 85) However, owing to the unprecedented decrease in family size and the drop in the fertility rate to an all-time low (1.37 births per woman in 1999) following the Austrian baby boom of the 1960s, national population size should begin to shrink as of 2024, according to OSTAT. (Central Intelligence Agency, p. 1; Solsten and McClave, p. 96; Federal Ministry, p. 9)

Nonetheless, as a result of the sheer number of elderly persons in Austria, the social health care system (as well as the pension system) is in danger of considerable strain as the pensioned older masses threaten to outnumber those who are currently employed and paying into social security. Prior to 1998, there were nearly 550,000 people over the age of 75 living in Austria, a figure that is projected to increase to at least 800,000 by 2021 — a 46 percent increase. At the same time, the number of people in the employment-eligible age group, 15 to 59, is expected to wane as of the year 2015. (Federal Ministry, p. 9) This population aging will also result in a greater incidence of disability and chronic illness.

However, Austria hopes it will weather the situation by continuing to trim health care costs and by raising the pensioning age, thereby allowing more older people to continue to support the system. According to Eleonora Hostasch, Austrian Federal Minister of Labor, Health and Social Affairs, the present goal regarding health care is to attempt to "maintain the [older] population in a healthy working condition," while raising the age in which people become eligible to receive pensions. (Hostasch) The current pension-eligible age sits at 65 for men and 60 for women. (Main Association..., p. 10) She has also said that there has been talk of shifting retirement from a single step to a series of "sliding" levels, reducing working hours until the person retires. (Hostasch)

Conclusion

The effect of recent reforms on increasing medical costs is already becoming apparent. Whereas in 1993 and 1994 medical costs had been rising by over 9 percent per annum, the rate of increase had slowed to just over 2 percent in 1996. (Federal Ministry, p. 87) Further provisions for cost-reducing policy are in the works. A mechanism to establish and monitor new quality standards is to be implemented, and a large-scale plan to further integrate all types of facilities responsible for health care is to be introduced. (Rack, p. 89) In addition, the new initiative to focus on preventive medicine is scheduled to continue with an expansion of proactive services, in particular for evaluation of early signs of chronic illness. (European Communities and WHO, p. 34)

Overall, whether the new changes being made in the provision of medical care will successfully allow the system to evade a clash with rising costs remains to be seen. Perhaps the ultimate solution to rising costs in Austria and the rest of the industrialized world lies in a process called rationing. The concept involves limiting medicine's use of expensive treatments with only marginally effective results and placing less emphasis on the development of new experimental technologies. Rationing would necessitate a change in basic health care ideology; that is, doctors and patients would have to accept that the medical community has knowledge of existing treatments that could possibly aid in someone's recovery but that these are cost-prohibitive. Piecemeal reform programs are targeted at trimming cost here and there and streamlining health care to evade administrative expenses. These are indeed necessary, but cannot serve as the ultimate solution. Health care ideology in industrialized nations includes a boundless search for and implementation of new procedures, and the price of these in coming years will in all likelihood not be accommodated by limited reform.

Whatever the method, it appears that considerable modification must still take place in Austria in order to safeguard the principle that every citizen fundamentally deserves equal access to high-quality health care. In these exciting times for the advancement of medical technology and the alteration of health care ideology, the world would do well to keep a close eye on Austria's solutions, as well as its mistakes, in order to discover newer and better approaches to keeping people healthy.

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